	APOLLO HOSPITALS, SECUNDERABAD	MOM – 04
		Issue: C
	POLICY AND PROCEDURE ON SAFE & RATIONAL PRESCRIPTION OF MEDICATIONS	Date: 06-01-2017
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1.1. PURPOSE

To define system to ensure uniformity and accuracy in prescribing medication.

2.1. SCOPE

This Policy and Procedure is applicable to all medications prescribed to a patient at Apollo Hospital, Secunderabad

3.1. DEFINITION


Attending Consultant - Consultant who is responsible for care of a patient for every treatment / care given during hospitalization.

High risk medication- High risk medications are defined as those medications which could cause an immediate life threatening condition for the patient if an error in the administration occurs.

4.1. RESPONSIBILITIES

Doctors, Nurses and Pharmacists are responsible to implement this policy and procedure.

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5.1. POLICY

5.2. Medications to be prescribed by attending physician or his / her team member or DMO only.

5.3. Medication orders to contain the following

Name of the medicine

Route of administration

Dose to be administered

Frequency/ time of administration


5.4. Medication orders are to be documented in a uniform location (medication chart) and should be “LEGIBLE” to read and understand what is prescribed.

5.5. Medication orders are to be signed with name, date & time by authorized prescribers.

5.6. Medications are to be prescribed in Generic Name/ Brand Name.

5.7. In case of medications bought by the patient from outside the organization/ Home medications, they would not be administered but the treating doctors/ consultant would document them in the medical reconciliation record at the time of initial assessment. Based on the patient diagnosis & plan of care the medications would be prescribed by the treating doctor/ Consultant

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5.8. In event of non availability of prescribed drug in Hospital Formulary (IP Pharmacy), Nurse should check with Pharmacy for alternate brand with same Strength and Potency.

5.9. Nurse should obtain permission from attending consultant to administer the available brand.

6.1. PROCEDURES


Prescription of Medication

- 6.1.1. Write the name of the drug with Strength (preferably in capital letters)
- 6.1.2. Before prescribing any drug ascertain the allergy status and record the same in specified column.
- 6.1.3. Write the 'time to be given' in the specified column in SOS / STAT Medication chart
- 6.1.4. Follow 'DO NOT USE ABBREVIATIONS LIST' given below when prescribing medications.

6.2. Uniform Location

- 6.2.1. All medications are to be prescribed in medication chart (normal condition) and SOS / Start Medication Chart (emergency condition) in patient case sheet. Nursing staff will follow the orders recorded in medication chart only.

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6.3. Correction

- 6.3.1. Do not SCRIBBLE / Smudge the entry
- 6.3.2. Draw a horizontal line across the entry so that the corrected information is accessible and put signature with name, date and time.
- 6.3.3. Write corrections in appropriate place

6.4. Verbal Orders (Emergency Use Only)


- 6.4.1. All verbal and telephonic orders should be given to concerned DMO or Nurse only by Treating doctor or his / her team member
- 6.4.2. All verbal order / telephonic orders should be checked & countersigned by doctor who had given the verbal / telephonic orders or his / her team member within 24 hours.

6.5. Read Back Mechanism

- 6.5.1. READ BACK mechanism should be followed for any information that is received telephonically or orally.
- 6.5.2. RECEIVER – who receives information? INFORMANT – who tells the information?
- 6.5.3. The receiver, after receiving information should read back to the informant to cross check.
- 6.5.4. This is to ensure the accuracy of information communicated between the informants and receivers.


6.6. DO NOT USE LIST – WHEN PRESCRIBING MEDICATIONS

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Do Not Use	Potential problem	Use Instead
U (unit)	Mistaken for "o" Zero, the number "4" (four) or cc	Write "unit"
IU (International Unit)	Mistaken for IV (Intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and O mistaken for "II"	Write "daily". Write "every other day"
Trailing Zero (X.O mg). Lack of leading Zero (.X mg)	Decimal point is missed	Write X mg. Write 0.X mg
MS MSO ₄ and MGSO ₄	Can mean Morphine sulfate or magnesium sulfate confused for one another	Write "morphine sulfate" Write "magnesium Sulfate"
<p>Applies to all orders and all medications - related documentation that is hand written (including free text computer entry) or pre printed forms.</p> <p>Exceptions: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter / tube sizes. It may not be used in medication orders or other medication - related documentation.</p>		


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6.7. ADDITIONAL ABBREVIATIONS, ACRONYMS AND SYMBOLS

Do Not Use	Potential problem	Use Instead
>(greater than) <(less than)	Misinterpreted as the number "7"(seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2"(two)	Write "at"
Cc	Mistaken for U (units) when poorly written	Write "ml" or "milliliters"
µg	Mistaken for mg (milligrams) resulting in one thousand - fold overdose.	Write "mcg" or "micrograms"

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6.8. HIGH RISK MEDICATION

6.8.1. All high risk medications are to be given to patient only after written orders (except emergency conditions).

6.8.2. All high risk medication orders are to be verified as per Policy and Procedure of medication administration.

List of high risk medications


1. Intravenous magnesium sulphate
2. Potassium chloride
3. Intravenous sodium chloride, concentrations greater than 0.9%
4. Narcotics
5. Neuromuscular blockers
6. Propofol
7. Look Alike and Sound Alike (LASA) Drug
8. Narrow Therapeutic Index Drugs (Warfarin, Digoxin, Lithium Carbonate, Carbamazepine, Phenytoin and Sodium Valproate)

6.9. CORRECTIVE & PREVENTIVE ACTION THROUGH AUDIT OF MEDICATION ORDERS

6.9.1. All the medication orders are audited by the Pharmacist of the unit before he/ she places the order. The Pharmacy staff who participates in the medication management system has access to important information about each patient in order to do the following:


6.9.2. Facilitate continuity of care treatment and service;

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- 6.9.3. An accurate medication history and a current list of medications (also known as a drug profile)
- 6.9.4. The patient information is available for those involved in the medication management system. This includes:
- 6.9.5. The patient's age (HIS System / Patient written medical record)
- 6.9.6. The patient's sex (HIS System / Patient written medical record)
- 6.9.7. The patient's current medications (HIS System / Patient written medical record)
- 6.9.8. The patient's diagnoses, co morbidities, and concurrently occurring conditions (Patient written medical record)
- 6.9.9. The patient's relevant laboratory values (HIS System / Patient written medical record)
- 6.9.10. The patient's allergies and past sensitivities (HIS System / Patient written medical record)
- 6.9.11. The patient's weight (measured height and weight are required for all pediatric patients) (HIS System / Patient written medical record)

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Once he receives all this information he checks for the following in the prescription given by the doctor/ Consultant in the drug chart.

1. Right drug
2. Right dose
3. Right frequency
4. Right ROA
5. Right Qty /day
6. Drug Interaction & CIs
7. Therapeutic duplication
8. Pharmacokinetic adjustments
9. Allergy information
10. Food -drug interactions

In case there is any discrepancy call is given to the care nurse & consultant for conformation & the processes the order for dispensing the medication

All the medication errors reported through incident forms, prescription audit & medication safety nurse are analyzed by root cause analysis & discussed in the Drug & Therapeutic Committee & preventive action recommended would be implemented & followed.

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